CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

September 24, 1998

H.R. 4567

Medicare Home Health Care Interim Payment System Refinement Act of 1998

As ordered reported by the House Committee on Ways and Means on September 18, 1998

SUMMARY

H.R. 4567 would revise Medicare payment rates for services furnished by home health agencies during cost reporting periods beginning in or after fiscal year 1999. The revised rates would be the basis for Medicare payments until a prospective payment system (PPS) for home health services is implemented.

The bill would increase the per visit cost limits from 105 percent of the median per visit costs to 108 percent. It would reduce the per beneficiary limit from 98 percent of the national median per beneficiary limit to 75 percent for agencies whose first cost reporting period begins in or after fiscal year 1999. And it would establish a floor for the per beneficiary cost limits for agencies whose first cost reporting period began before fiscal year 1999.

For agencies that had a cost reporting period ending in fiscal year 1994, the per beneficiary limit would be the greater of the agency's current per beneficiary limit and the average of the agency's current per beneficiary limit and the national median per beneficiary limit. For home health agencies without a cost reporting period ending in fiscal year 1994, but with a cost reporting period beginning before fiscal year 1999, the per beneficiary limit would be the greater of the agency's current per beneficiary limit and the national median per beneficiary limit.

The change in Medicare Part B spending resulting from enactment of H.R. 4567 would not be included in the calculation of the Part B premium until a PPS for home health services is implemented.

CBO estimates that enacting H.R. 4567 would increase federal spending by $0.2 billion in 1999 and $1.3 billion over the 1999-2003 period. This legislation would affect direct spending; therefore pay-as-you-go procedures would apply.

The legislation does not contain any intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act. The bill would result in additional Medicaid costs to states of between $1 million and $14 million annually, totaling approximately $75 million for the 1999-2008 period. However, states possess sufficient flexibility to alter their programmatic or financial responsibilities to offset these additional costs.

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of H.R. 4567 is shown in the following table. The costs of this legislation fall within budget functions 550 and 570 (Health and Medicare).

	By Fiscal Year, in Billions of Dollars					
	1998	1999	2000	2001	2002	2003
CHANGES IN DIRECT SPENDING						
Medicare						
Fee-for-service home health benefits	0	0.2	0.2	0.2	0.2	0.2
Payments to Medicare+Choice plans	0	0	a	0.1	0.1	0.1
Part B premiums	0	0	0	a	a	a
Subtotal	0	0.2	0.2	0.3	0.3	0.3
Medicaid	0	0	0	a	a	a
Total	0	0.2	0.2	0.3	0.3	0.3

Note: Details may not add to totals due to rounding.

a. Costs or savings less than $50 million.

BASIS OF ESTIMATE

Medicare Fee-For-Service Home Health Benefits. Medicare pays home health agencies the least of three amounts: the agency's reasonable costs, a limit calculated on a per beneficiary basis, or a limit calculated on a per visit basis. H.R. 4567 would increase the per visit limit, and it would increase the per beneficiary limit for most agencies. The per beneficiary limit would be reduced for agencies that did not participate in Medicare before fiscal year 1999.

The higher proposed per visit and per beneficiary limits would result in higher rates of utilization and higher payments per beneficiary in agencies subject to those limits under current law. The reduction in the per beneficiary limit for agencies not already participating in Medicare would substantially reduce the entry of new firms. The estimate assumes, however, that existing agencies would expand to provide most of the services that would have been furnished by new entrants.

CBO analyzed the effects of changes in payment rates and utilization using data from a sample of cost reports for home health agencies. In aggregate, CBO estimates the bill would increase payments to home health agencies by $0.2 billion in 1999 and $1.1 billion over the 1999-2003 period.

Payments to Medicare+Choice Plans. Higher Medicare spending for home health services in the fee-for-service sector would lead to higher capitated payments to Medicare+Choice plans beginning in 2000, because annual updates to Medicare+Choice payment rates are based on changes in per capita spending in the fee-for-service sector. CBO estimates that enactment of H.R. 4567 would increase Medicare fee-for-service spending by about 0.1 percent, which would increase payments to Medicare+Choice plans by $0.3 billion over the 1999-2003 period.

Part B Premiums. The Balanced Budget Act of 1997 (BBA) transferred coverage of certain home health services from Part A of Medicare to Part B. In general, the Part B premium would cover 25 percent of the additional Part B spending. However, the BBA also required that the effect on Part B premiums of the transferred home health spending be phased-in over a seven year period. Enactment of H.R. 4567 would increase Part B spending; however, the bill specifies that the effect of this increase not be incorporated into the Part B premium until a prospective payment system is implemented for home health services.

The BBA requires the Secretary of Health and Human Services to implement a PPS for home health services in fiscal year 2000. CBO assumes implementation of the PPS will be delayed because the analytic work needed to develop a system of categorizing cases that is clinically sound and that groups cases with comparable costs will not be completed in time. This analytic work will be further delayed by Medicare's Year 2000 computer problems. The estimate assumes that a PPS could be implemented as early as 2001 and will be implemented no later than 2004.

To estimate the effect of H.R. 4567 on Part B premium receipts, we first assumed implementation of a PPS for home health services and estimated the increase in Part B premiums that would result from higher Part B payments to home health agencies and Medicare+Choice plans. We then adjusted the estimated premium receipts to reflect the probability of implementation of a PPS. CBO estimates that Part B premium receipts would be unchanged in 1999 and would increase by about $0.1 billion over the 1999-2003 period and by $0.5 billion during 1999-2008.

Medicaid. Medicaid pays the part B premium for beneficiaries enrolled in both Medicare and Medicaid. As a result of the increase in the Part B premium, CBO estimates that federal spending for Medicaid would increase by less than $50 million over the 1999-2003 period and by $100 million during 1999-2008. The increase in Medicaid spending by states would total about $75 million during the ten-year period.

PAY-AS-YOU-GO CONSIDERATIONS

Section 252 of the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. The net changes in outlays and governmental receipts that are subject to pay-as-you-go procedures are shown in the following table. For the purposes of enforcing pay-as-you-go procedures, only the effects in the current year, the budget year, and the succeeding four years are counted.

	By Fiscal Year, in Millions of Dollars										
	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Changes in outlays	0	200	200	300	300	300	300	400	400	400	400

INTERGOVERNMENTAL AND PRIVATE-SECTOR IMPACT

H.R. 4567 contains no private-sector or intergovernmental mandates as defined in the Unfunded Mandates Reform Act. The bill would result in additional Medicaid costs to states of between $1 million and $14 million annually, totaling approximately $75 million for the 1999-2008 period. However, states possess sufficient flexibility to alter their programmatic or financial responsibilities to offset these additional costs.

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